

National Institute of Health Sciences

Research Bulletin

**Volume 2
Issue 4**

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The National Institute of Health Sciences (NIHS)

The NIHS operates in direct response to the national Health Research Strategy *Making Knowledge Work for Health: A Strategy for Health Research* (2001). Its remit is to develop a health-related educational and research infrastructure in the Mid-Western region, build a culture that fosters health research, and support people in quality research for health. It is now in its fifth year of publishing and promoting research.

At the core of the NIHS is the alliance between the Mid-Western Health Board (MWHB) and the University of Limerick (UL), formally launched in 2003. This alliance is bridging the gap between the academic world and the various professions in the health care sector, adopting a partnership approach to developing a thriving research culture. The NIHS promotes and facilitates advances in health-related post-graduate education and research, and provides information resources to support research.

The NIHS invites all MWHB staff members to acquaint themselves with its resources and activities. Membership of the NIHS e-library is open to all MWHB staff. The NIHS looks forward to assisting in the continuing consolidation of the research culture of this region.

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Call for Abstracts for Next Issue of the NIHS Research Bulletin

Abstract Submission Guidelines

Foreword

This issue of the National Institute of Health Sciences Research Bulletin once again brings to our attention the wealth of research activity from across a broad spectrum of healthcare arenas. Such energy and enthusiasm for new knowledge underpins the buoyant research culture of this region.

I gratefully acknowledge the dedication and efforts of the wide range of busy practitioners and healthcare professionals engaged in research who have contributed to this issue. Their contributions are an invaluable asset to the promotion of excellence within our healthcare services and of a thriving research culture from which all can benefit.

I am indebted to our editorial team Professor Pierce Grace, Professor John Fenton, Mr Pat Brosnan and Mr Aidan Hickey for their commitment and professionalism.

Stiofán de Búrca Ph.D.

Príomh Oifigeach Feidhmeacháin

‘Health research plays a crucial role in the ongoing development and provision of quality healthcare that best meets the needs of individuals and the population.’ Thus quotes the *National Health Information Strategy (NHIS)*, launched in July 2004. Its release completes the suite of reports that address the Health Service Reform Programme’s six frameworks for change.

This strategy formalises government’s commitment to the modernisation of our health information framework, away from a state of fragmentation, under-resourcing, and under-utilisation, to the provision of complete, comprehensive, accurate, timely and standardised information, that serves the ultimate goal of evidence-based decision-making and high-quality care. Its importance for the achievement of the four goals of the Health Strategy, *Quality and Fairness* (2001) – better health for everyone, fair access, responsive and appropriate care and high performance-cannot be overemphasised.

Researchers are a key stakeholder group. This publication is significant in realising the vision behind the Health Research Strategy, *Making Knowledge Work for Health* (2000), where it is acknowledged that researchers need access to high quality information and information systems, to sophisticated databases and biological banks, to libraries and to information technology.

Issues of vital significance to the research community are addressed: capturing and dissemination of high quality and standardised health-related data, unique identification, implementation of the electronic healthcare record, access to world-class bibliographic databases, access to statistical data and databases via a Health Information Portal, the establishment of a health services data model and a national population health observatory, issuing of a Health Information Bill and governance codes of practice and multi-annual information and ICT planning. The NHIS explicitly commits to the technological and organisational infrastructure, processes and governance framework necessary to support the research and development function as set out in the Health Research Strategy. It also commits to sufficient specialist analytical, interpretive and information services expertise.

Significant challenges lie ahead in implementing this strategy: unravelling the legislative complications behind unique identification, creating a robust information governance framework, addressing unprecedented management, cultural, and organisational challenges and ensuring significant and sustained investment in the human and technological infrastructure.

As part of the research community, we support the significant developments heralded in this strategy. We acknowledge the challenges, pledge our contribution to its success, and look forward to seeing the immense benefits its implementation will deliver.

Aidan J. Hickey

Director

National Institute of Health Sciences

Prevalence of Smoking among Diabetic Patients in the Mid-West Region*O'Connor, R.,¹ Haughton, F.,² O'Connell, E.³**Mid-Western Health Board Training Scheme in General Practice, University of Limerick¹**Department of Public Health, Mid-Western Health Board, Limerick²**Department of Statistics, University of Limerick³***Introduction**

Cardiovascular disease is substantially increased in diabetes mellitus and is the chief cause of death.¹ It is significantly exacerbated by tobacco smoking. Ideally, no diabetic should smoke. Currently, smoking prevalence among the general population in Ireland is 31%.²

Objective

To determine the prevalence of tobacco smoking among diabetic patients in a nationally representative sample in the Mid-West region of Ireland.

Methodology

This was a cross sectional study. General practitioners working in the Mid-Western Health Board region were identified from the Primary Care Unit listing. Doctors working in Limerick City, Co. Limerick and Co. Clare were randomly selected. The selection process aimed to match the sample to a nationally representative pattern using data from the Irish College of General Practitioners national general practice study (1997). Verbal consent was obtained by a phone call from the principal investigator (RO'C). Following this a questionnaire was posted to the practice. After two weeks, a telephone reminder was given to non-responding practices.

Results

Fifty two questionnaires were distributed. Twenty seven were returned giving a response rate of 54%. Data from 1,030 diabetic patients was obtained. It is estimated that this number represents between 9 and 15% of the total number of diabetics in the region (Dr. James O'Hare, personal communication).

Of these, 201 were Type 1 and 829 were Type 2. Five patients did not have smoking data recorded. The results are shown in Table 1.

Table 1 - Smoking status of diabetic patients**Smoker**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	855	83.0	83.4	83.4
	Yes	170	16.5	16.6	100.0
	Total	1025	99.5	100.0	
Missing	System	5	.5		
Total		1030	100.0		

- *83.4% of diabetic patients do not smoke*
- *16.6% of diabetic patients do smoke*

Conclusion

The rate of tobacco smoking among diabetic patients in the Mid-West region is approximately half of the national rates for the entire population. Although this is encouraging, there is still much scope for improvement.

References

1. Watkins PJ. Cardiovascular disease, diabetes and lipids. BMJ.2003;326:874-6.
2. Health Promotion Centre, National University of Ireland, Galway. The National Health and Lifestyle Survey. Feb 1999.

Funding

This research project has received funding from The Research and Education Committee of the Department of Health and Children.

Audit of Stroke Recurrence, Mortality Rates and Discharge Destinations in a Stroke Unit Population

*Rasheed, S., Carew, S., Almatouq, S., Pillay, I., Donnelly, T., Lyons, D., O'Riordan, R., Ryan, M.
Clinical Age Assessment Unit, Mid-Western Regional Hospital, Limerick*

Introduction

Stroke Unit care offers significant mortality advantages to patients compared with conventional medical care. We have a six-bedded Stroke Unit, which provides rehabilitated stroke care. We examined stroke recurrence, mortality outcomes and discharge destinations over a 33 month period.

Methodology

Patient details were obtained from the stroke database (Filemaker Pro 5.5) from September 2000 to June 2003. Patient outcome data was obtained from a combination of General Practitioner records, hospital records, register of deaths and from patients and their relatives.

Results

185 consecutive admissions to the Stroke Unit between September 2000 and June 2003 were examined. Mean age (SD) was 75 (8.996) years. There was no significant gender difference in patients admitted. (51% male; 49% female). Stroke recurrence was 4% (n = 8) over the 33 month period. Mortality was 25% (n = 46). Discharge data showed that 72% were discharged home (n = 134), 14% (n = 26) to Nursing Home and 14% (n = 26) to Continuing Care. No patient died as the direct result of recurrent stroke.

Discussion

We demonstrate low stroke recurrence and mortality rates. Previous audits of the unit show compliance with secondary prevention, which may account for this.

Conclusion

Our data compares favorably with published data in relation to stroke. We clearly demonstrate improved mortality rate and stroke recurrence rate in a dedicated stroke unit.

Presented

As a poster presentation at the Irish Geriatric Society Meeting in the University of Limerick in September 2004.

The Correlation of Clinical History and Tilt Table in the Diagnosis of Syncope

Donnelly, T., O'Connor, M., Pope, G., McManus, J., Pillay, I., Lyons, D., Watts, M., Clinch, D.
Clinical Age Assessment Unit, Mid-Western Regional Hospital, Limerick

Introduction

The diagnosis of Syncope is a prerequisite to treating patients and advising with regard to prognosis. Using standardised evaluations history, physical exam and ECG tracings the yield can be as high as 50%. The use of physician expertise in the taking of a medical history and evaluating physical signs allows appropriate investigation to establish the diagnosis. The use of head up tilt with phasic blood pressure monitoring has been shown to be a powerful tool in the diagnosis of patients with neurally mediated or orthostatic syncope. The aim of this study was to correlate the predictability of history taking of two independent physicians in the diagnosis of syncope in those referred for head up tilt (HUT).

Methodology

63 consecutive patients who had experienced syncope or pre-syncope over a six month period and were eligible for syncope studies. The clinical indication for tilt testing by the referring medical physician was recorded. The SpR performing the syncope study made an independent clinical diagnosis based on history prior to HUT. The diagnosis on tilt testing was then compared to the two clinical diagnoses made prior to the test.

Results

63 patients studied, 22 males, 41 females with an average age of 77 years (range 14-93). 39 patients (61.9%) had a positive diagnostic HUT. 11 had orthostatic hypotension, 15 Carotid Sinus Syndrome (CSS), 5 had neurocardiogenic syncope and 3 patients were diagnosed with postural orthostatic tachycardia (POTS).

Table 1 - History correlation with diagnosis

	Orthostatic Hypotension	Neurocardiogenic	Carotid	POTS
Investigator 1	29%	2%	23%	0%
Investigator 2	11%	2%	15%	0%
Investigator 1 +2	58%	96%	61%	0%
Tilt	1%	0%	1%	3%

Conclusion

Clinical history, taken by the referring physician in conjunction with assessment within a specialised syncope unit was shown to correlate highly with a positive tilt table result in those referred with unexplained syncope. The study highlighted the powerful role of tilt table testing in appropriately selected patients as a diagnostic tool in identifying or excluding orthostatic or neurally mediated syncope.

Presented

As a poster presentation at the Irish Geriatric Society Meeting in the University of Limerick in September 2004.

Recurrence Rate of Tia or Stroke: An Acute Outpatient Setting

O'Connor, M., McCarthy, A., Carew, S., O'Sullivan, C., Curtain, M., Donnelly, T., McManus, J., Pope, G., Pillay, I., Lyons, D., Clinch, D., Watts, M.
Clinical Age Assessment Unit, Mid-Western Regional Hospital, Dooradoyle, Limerick

Introduction

Stroke is the third leading cause of death in Ireland. A previous transient ischaemic attack (TIA) or stroke is a major risk factor for a subsequent event. The recent Oxford Vascular Study showed that there was up to 18.5% risk of recurrence of stroke at three months, after an initial TIA or minor stroke.

Methodology

Data were compiled from a customised database. All patients who were diagnosed with a TIA or minor stroke in an acute medical assessment unit within a 26-month period were identified. A telephone interview was carried out to determine recurrence of stroke or TIA and smoking status.

Results

- 39 patients were studied.
- 26 patients were identified with a diagnosis of TIA, 13 with a diagnosis of stroke.
- Mean follow-up time was 11 months (range 1-26 months).
- Mean age was 65 years (Range 44 - 92 years).
- 2 of 39 patients (5.1%) had a further stroke/TIA despite rapid medical assessment and aggressive risk factor modification.
- 1 of 39 patients died of pneumonia (9 months after the initial stroke).
- 6 of 36 patients (17%) are current smokers.

Conclusion

Risk of a recurrent stroke or TIA after maximum vascular risk factor modification in an acute medical assessment unit is 5.1%. This result compares favourably with the recent Oxford Vascular Study. This would suggest that management of these patients via the outpatient acute medical assessment unit is satisfactory. Measures to target smoking cessation need to be addressed.

Presented

As a poster presentation at the Irish Geriatric Society Meeting in the University of Limerick in September 2004.

Reference

Coull AJ, Lovett JK, Rothwell PM. Oxford Vascular Project. BMJ.2004; 328:326.

Vigorous Management of Hypertension in a Medical Assessment Unit

Pope, G., Sulaiman, H.M., Almatouq, S., Craig, O., Watts, M.
Department of Medicine for the Elderly, Clinical Age Assessment Unit,
Mid-Western Regional Hospital, Limerick

Introduction

Hypertensive treatment reduces myocardial infarction by 20–25% and stroke by 35–40% (*Lancet* **356** (2000), pp. 1955–1964). Our region has the highest age standardised death rate from cardiovascular disease at 174.6 per 100,000 (Central statistics office 2001). This study analyses hypertensive management in an acute medical assessment unit.

Methodology

Known and newly diagnosed hypertensive patients were identified using a customised unit database. The mean age was 67.7 years. Cardiovascular risk factor profile, investigations, treatment and blood pressure control information were obtained from patient records. These were compared with the British Hypertension guidelines 2004.

Results

In a four month period 39 patients were identified with hypertension. 10 of these were referred specifically for management of hypertension. The mean age was 67.7 (38.5% male, 61.5% female). All referrals specifically for hypertension and 52% of known hypertensive patients had 24 hour blood pressures. A mean reduction in blood pressure of 6.2/3.9 mmHg was achieved in those referred specifically for the management of hypertension. 7% were formally advised weight reduction, 10% salt reduction and 3% exercise. 14% of smokers were advised to stop. Written advice was not given.

Overall 32 patients had at least 1 other cardiovascular risk factor. Of these 34% were prescribed aspirin, 25% aspirin with a statin and 13% a statin alone. 28 % of those with co-existing risk factors were not commenced on additional medications other than antihypertensives. Investigations and treatments were complete and appropriate in accordance with the BHS guidelines.

Conclusion

A larger series of patients with prospective follow up is required to further evaluate the role of a medical assessment unit in hypertensive management. A standardised written advice sheet should be implemented for non-pharmacological advice and administered to all patients with hypertension. This would include a smoking cessation plan, exercise strategy, diet, weight and salt modification program. A medical assessment unit is an ideal location for assessing and treating hypertension. It has an important role in early identification and treatment of co-existing vascular risk factors.

Presented

As a poster presentation at the Irish Geriatric Society Meeting in the University of Limerick in September 2004.

An Audit of a New Acute Assessment Ward for the Elderly

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Introduction

Nenagh General Hospital is a small hospital serving a mostly rural population. The Acute Assessment Ward for the Elderly (8 Beds) opened in September 2002. An audit was carried out to establish baseline of ward activity from January 1st to May 31st, 2004. The total number of admissions was 113.

Methodology

The records of 96 patients were examined manually. 17 patients admitted to the unit were general medical patients of other Consultants and were not included in the Audit. Source of Admission, Age, Mental Test Score, Barthel Index, Waterlow Score, Length of Stay and Discharge destination were recorded.

Results

Nenagh Hospital has a direct admission policy. 28 patients were admitted directly to the ward. 41 patients spent an average of 3.5 days on other wards including I.C.U. prior to, or during admission to Elderly Care. The remaining patients were transferred within 24 hours of admission. The average length of stay in the unit was 11 days. Age ranged from 70-95 years.

Source of Admission:

60 G.P referrals from home; 20 from Nursing Homes; 6 from medical out-patients; 5 from Community Geriatric Hospital/Nursing Units and 5 self-referrals via A+E.

Discharge destination:

41 patients were discharged home. All were referred to Public Health Nurse. 1 patient refused all community supports, 22 patients were discharged to nursing homes and local geriatric units, where they were resident prior to admission. 8 patients were discharged to the Hospital Of Assumption, Thurles. 16 patients admitted from home were discharged to nursing homes. 2 patients were transferred to other hospitals. 7 patients died.

Conclusion

The audit demonstrates the nature of the workload in our acute assessment unit for the elderly. Traditional community supports are still very much in evidence, which allows people to live in dignity in their own homes. In a rural area elderly people expect and get much support from neighbours and family. Private nursing home care is an obvious choice for people who can no longer live at home because of this rural community network. Family and neighbour support, availability of Nursing Home beds and Health Board beds have helped the rapid throughput in the unit. This may be difficult to sustain in the future when the local geriatric hospital is rebuilt at a smaller size.

Presented

At the Irish Gerontological Society Conference in the University of Limerick on September 10th and 11th, 2004 by Sr. Ann Hickey.

Warfarin in the Mid-Western Health Board: Audit of prevalence, indications for use and haemorrhagic events

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 Department of Haematology, Cork University Hospital, Cork²

Introduction

Warfarin is the standard oral anticoagulant used in Ireland. The most common associated complication of Warfarin use is haemorrhage.

Rationale

The delivery of care to warfarinised patients in the Mid-Western Health Board has undergone major changes between 1999 and 2002. Quality improvements include the increased use of computerised dosing, specialised nursing input into monitoring patients and the use of near patient testing for selected patients.

Methodology

In order to evaluate the progression of the Health Board's anticoagulation service, we undertook an audit of the incidence of Warfarin use, haemorrhagic events in patients who presented with INR 5.0 readings and associated methods of INR reversal. We evaluated patient's knowledge and satisfaction with the service provided and furthermore compared different existing methods of INR control. The audit spanned a 12 month period from October 2002 to October 2003.

Results

- The number of patients receiving Warfarin therapy was estimated to be 2,564 (0.76% of the Mid-Western Health Board's population according to the 2002 census)
- The most common indication for warfarinisation was atrial fibrillation (54%)
- The most frequent cause of loss of INR stability was drug interaction (43%)
- In 77% of these cases, INR reversal was achieved through Warfarin dose omission or reduction alone. Only 3.3% of cases required the administration of either Fresh Frozen Plasma or Prothrombin Complex Concentrate.
- The incidence of haemorrhage in patients with INR 5 values was 16.6%, with the most common sites being genitourinary (39%) and gastrointestinal (27%). No fatal or intracranial haemorrhage was reported during the audit period.
- In a survey of one hundred Warfarin clinic patients, 38% failed to identify all 3 Warfarin tablets. When presented with the hypothetical situation of missing a dose, 5% stated they would take a double-dose the following day. 28% of patients were not aware of the risk of taking aspirin and 33% did not understand the dangers of alcohol while on Warfarin.
- In a comparison of clinic patients and those monitored exclusively by their general practitioner, clinic patients had a lower incidence of over-anticoagulation (4.9% versus 6.6%), had their INR readings within therapeutic range more often (62% versus 56%) and had a shorter review time (28 days versus 33 days).

Conclusions

The number of patients on oral anticoagulants has increased rapidly over the past five years, principally due to the large number of elderly patients with chronic atrial fibrillation commenced on this therapy for the prevention of stroke. The high incidence of drug interaction as a cause of loss of INR control needs to be addressed by more frequent monitoring of the INR upon commencing a new drug or ideally by prescribing a non-interacting drug. The high incidence of using Warfarin dose omission or reduction only as a means of INR reversal is encouraging. From the clinic survey it is clear that a significant minority of patients are at risk from complications due to inadequate knowledge. We suggest a programme of continuous education for patients should produce a more stable INR control which would reduce the burden on the patient, on medical staff and on the Health Board services.

References

Available on Request

Funding

This research has been funded by the Mid-Western Health Board.

The Facial Nerve; One Editorial, Two Authors, Top-Cited

Fenton, J.E., Wormald, R., O'Connor, A., Skinner, L., Ahmed, I.
Mid-Western Regional Hospital and National Institute of Health Sciences, Limerick

Introduction

The Science Citation Index (SCI) was introduced primarily as a method of information retrieval such that a researcher can discover if a paper has been included as a reference in other publications. Citation analysis has also been used as an objective measure of the quality of an article in that the number of times that it has been cited or the citation score suggests a notable impact on the relevant scientific community. This information source allows an author to assess supportive or argumentative discussion on a relevant topic and to produce a more accurate and impartial literature review.

Objective

The aim of this study was to identify the most-cited article in otolaryngology/head and neck surgery journals and to provide a snapshot of the papers that cited it.

Methodology

Using a database provided by the Institute of Scientific Information (Philadelphia, PA) the most cited article in 28 clinical otolaryngology/head and neck journals and the papers that referenced it were identified. This was an editorial published in *Otolaryngology Head Neck Surgery* in 1985 by House and Brackmann on a grading system for the categorization of facial nerve function.

Result

The article received 494 citations from a broad spectrum of specialties involved in the management of the facial nerve.

Conclusion

The majority of citations were by articles published in otolaryngology/head and neck surgery or neurosurgery journals and were supportive of the system. However, the high citation rate is also due to the perceived shortcomings and lack of universal acceptance of the classification.

Presented

1. At the 4th International Skull Base Society in Sydney, Australia on November 4th, 2004 by Professor John Fenton.
2. Professor Fenton has been invited to present this research at an International Facial Nerve meeting due to be held in Holland in September 2005.

The Role of RAST in Patients with Rhinitis

Young, O.,¹ Fenton, J.E.,¹ Barrett, N.²

Department of Otolaryngology, Mid-Western Regional Hospital, Limerick¹

Department of Biochemistry, Mid-Western Regional Hospital, Limerick²

Introduction

Allergic rhinitis represents a global health issue affecting 10-25% of the world's population. The disease carries a substantial economic impact with an estimated \$600 million spent annually in the US in the management of the condition.

Rationale

The aim of our study was to audit the use of RAST testing in the investigation of Allergic Rhinitis in our unit. Our current practice is to request a total serum IgE assay and subsequent RAST test in patients who present with a history and examination suggestive of Allergic Rhinitis.

Methodology

A manual search through all RAST requests originating from the ENT department from June to November 2003 was undertaken.

Results

In total, 183 samples were taken, of whom 56 went on for full RAST analysis (30.6%). Of those, 26 were in the paediatric population and 30 were adult. A total IgE assay costs a mere 3 euro, while processing the Children's atopic panel costs 47 and the adult UK food and inhalant panel costs 66 euro. This amounts to a total cost of 7,500 euro annually. Allergic rhinitis was also found to be the second most common reason for RAST to be requested from our Biochemistry department.

Conclusions

Our results concur with published literature that the link between total IgE and the presence of clinical allergy and allergen-specific IgE is tenuous and raises the question of the relevance of using total IgE as a screening tool at all. A positive result for both strains of dust mite was our most common finding in the adult and paediatric population in keeping with reports in the world literature. As the worldwide prevalence of allergy increases, the literature is replete with examples illustrating the favourable response of atopic individuals when allergens are controlled within their immediate environment. The use of RAST testing affords us the opportunity to empower our patients to make such changes.

Presented

At the Irish Academy of Otolaryngology, Head and Neck Surgery Meeting in Killarney on April 3rd, 2004 by Dr. Orla Young.

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Information Leaflets for Patients with Venous Leg Ulcers – Are They Beneficial?

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Introduction

Written information provides patients with permanent, reusable material, which they can refer to at their leisure. The Department of Vascular Surgery identified the need to provide leg ulcer patients with verbal and written information regarding their condition with the aim of improving knowledge of treatment.

Methodology

Following a consultative process involving patients, medical and nursing staff and a psychologist in formulating content and presentation, we designed an information leaflet for patients with leg ulcers. The leaflet was tested for readability, which indicated that the majority of people would understand the information. Although mountains of leaflets for patients are produced regularly, relatively few studies have been performed to evaluate their usefulness and readability. We tested the hypothesis that patients with venous ulcers who receive written information retain more knowledge about their condition than patients who receive verbal information alone.

In this pragmatic trial, 20 patients, mean age of 68 years, newly diagnosed with venous ulceration were recruited. 10 patients were randomised to the control group and were given clear verbal information on their condition and 10 patients were randomised to the intervention group who received the same verbal information in addition to a patient information leaflet. At the initial visit all patients participated in a short structured interview, which determined baseline knowledge of their condition. At a follow-up visit, between 4-6 weeks later, the patients again participated in a structured interview to determine change in knowledge levels.

Results

At follow up, both groups showed an overall improvement in knowledge. However, when the difference in total scores at baseline and follow-up between control and treatment groups was tested there was no significant difference in the results ($p=0.83$), indicating that the provision of leaflets to this elderly patient group may not be beneficial. We also noted that the highest level of education completed by 65% of those participating in the study was primary level education; a further 30% completed some level of secondary education and only 5% attended third level education.

Conclusion

The results from this study indicate a limited value of providing information leaflets to this patient group, which predominantly are older patients with low levels of education. The disappointing results may also be due to the relatively small sample size, the age of the patients or their lack of educational achievement. Further research with larger numbers addressing these issues may be beneficial.

Can General Surgeons Care For Paediatric Trauma Patients In Regional Hospitals Without Paediatric Surgeons?

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Introduction

Several reports have suggested that all severely injured paediatric patients should be managed in a regional paediatric trauma centre to ensure the best possible outcome. However, in the Republic of Ireland there are no paediatric hospitals outside of Dublin, so most paediatric trauma patients are managed by general surgeons.

Methodology

We carried out a retrospective audit of all paediatric patients admitted with trauma to our institution between January 2000 and December 2001. Inclusion criteria were age less than 14 years and admission as a result of accidental injury.

Results

One hundred and fifty four (n=154) patients were admitted with trauma during the two year period. There were 96 boys (62%). Median age was four years (0.2-14 years). Falls were the commonest cause of injury (57%), followed by RTA (21.4%), burns (10%), blunt injury (8.4%) and penetrating injuries accounting for (4%). Mean ISS was 11 ± 6.36 (SEM).

Twenty nine patients (19%) required a surgical procedure:

- wound exploration (n=21, 14%)
- chest drain insertion (n=3, 2%)
- exploratory laparotomy (n=4, 2.6%)
- scrotal exploration (n=1, 0.6%).

Seventeen patients (11%) were referred to specialist units:

- 13 (8.4%) to plastic surgery
- 3 (1.9%) to neurosurgery
- 1 (0.64%) to a spinal unit.

There was one mortality (0.6%) due to a severe head injury. The majority of our patients had minor trauma.

There were no unexpected deaths in our study but there were four unexpected survivors (probability of survival score <0.5).

Conclusion

Although the majority of our patients had minor trauma, the seriously injured children were successfully treated with no unexpected deaths. This shows that appropriate care is being provided by general surgeons to paediatric trauma patients in regional hospitals.

An Audit of Ultrasound Assisted Hickman Catheter Insertion in Patients Receiving Chemotherapy

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Introduction

Hickman catheters have been shown to provide safe long-term venous access for patients with malignant diseases. In many centres catheters are placed using fluoroscopic guidance. We hypothesised that ultrasound-assisted catheter placement by surgeons in the operating theatre would be a simple, safe and effective alternative technique with reduced infective complication rates.

Methodology

Hickman catheter insertions between May 1998 and March 2002 were studied. The data were collected from the Hospital Inpatient Enquiry database and the case-notes of all patients were reviewed. Percutaneous catheter placement with tunnelling was performed in the operating theatre after scanning the internal jugular vein (IJV) for position, size and patency, using a Pie 100LC Scanner (Pie Medical, Maastricht). A standard chest radiograph confirmed catheter position at the end of the procedure.

Results

58 patients (30 males and 28 females) had 65 Hickman catheters inserted. The median age was 60 years (range 32-82 years). Catheter placement was achieved in all patients, 59 in the right IJV and 6 in the left. Ultrasound scanning demonstrated that the right IJV was thrombosed in 6 patients (10%), thus avoiding unnecessary attempts at cannulation. The Hickman catheters remained in situ for a combined total of 5,857 days (median, 89 days, range 4-485 days). Immediate complications occurred in two patients (pneumothorax in both). One patient required a chest drain. The overall sepsis rate was 3.92 per 1,000 catheter days. Systemic sepsis was slightly higher (2.21 per 1,000 catheter days) than superficial sepsis (1.71 per 1,000 catheter days). In all the patients who developed systemic sepsis the catheter had to be removed (n=13). All the superficial infections were treated successfully with antibiotics (n=10 patients). Two catheters developed thrombosis.

Conclusion

We conclude that ultrasound-assisted percutaneous placement of Hickman catheters in the operating suite is a simple, safe and effective technique with a low rate of infective complications.

Is the Admitting Diagnosis made by Non-Consultant Hospital Doctors in Acute Surgical Patients Accurate?

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Introduction

The incidence of accurate diagnosis made by non-consultant hospital doctors (NCHDs) is unknown in acute surgical patients admitted via an accident and emergency department. There is a common assumption that reliance is made on excessive investigations some of which may be inappropriate.

The aim of this study was to assess the accuracy of admitting diagnosis by the NCHDs and the appropriateness of diagnostic investigations ordered, also to assess the influence of these investigations and of consultant input on getting the final diagnosis after admission.

Methodology

Data were collected prospectively from July 1st 2003 on 100 consecutive acute surgical admissions. Demographic and clinical data including admitting diagnosis (NCHDs), time of admission, investigations performed and final diagnoses (Consultant's) were collected. Investigations were considered appropriate if they were relevant and confirmed the diagnosis.

Results

Data were available on all the patients. A final diagnosis was made in all the patients. 79 % (n=79) of patients had accurate initial diagnosis (NCHDs). 29.1% (n=23) of these had scans; all were positive and confirmed the initial diagnosis. Out of 21% (n=21) initial inaccurate diagnoses, 47.6 % (n=10) patients were diagnosed on repeated clinical examination or evaluation by consultant surgeon, 23.8% (n=5) patients on the basis of clinical examination alone and another 23.8% (n=5) by a combination of clinical examination and imaging. Final diagnosis was made on imaging alone in 23.8% (n=5) and in the remaining 28.5% (n=6) by endoscopy or surgical intervention. 52.3% (n=11) had scans out of which 63.6% (n=7) were positive and helped final diagnoses. We found that the clinical course of the disease and the investigations carried out are the main reasons for the difference between the admitting and the discharge diagnosis.

Conclusions

79% of initial diagnoses made by NCHDs in acute surgical admissions via accident and emergency department with off site consultation by the consultant on call are the accurate final diagnoses. An additional 10% of final diagnoses were made by further clinical evaluation and the help of the investigations. The utilization of diagnostic modalities especially radiological imaging is highly appropriate. Our study suggests that the physical presence of a consultant on site would not lead to significant improvement to the delivery of health care to the Irish population.

Presented

At the Sylvester O'Halloran Surgical Scientific Meeting in the University of Limerick on March 5th and 6th, 2004 by Mr. S.T.M. Cheema.

Published

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Preoperative Factors Influence the Outcome of the Emergency Repair of the Ruptured Abdominal Aortic Aneurysm

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Introduction

Despite the increasing longevity of man and the decreasing mortality of elective aortic surgery, repair of a ruptured abdominal aortic aneurysm (AAA) has multifactors which are responsible for the outcome. Survival following emergency surgery for ruptured abdominal aortic aneurysm remains poor and is in stark contrast to that for elective repair.¹ The larger aneurysms are more likely to rupture than smaller ones. An autopsy study verified this finding.² Some of these factors have been investigated in this study.

Methodology

The records of the 42 patients with a primary diagnosis of Ruptured AAA admitted to the Vascular Unit at University College Hospital, Galway during the period of April 1996 to March 2001 (5 years) were reviewed. The variables investigated for their association with surgical mortality (30 days) rates for ruptured AAA includes age, preoperative haemoglobin, systolic blood pressure, and serum creatinine level at the time of admission.

Results

Out of the 42 patients who went for emergency AAA repair, 19 (45%) of patients died within 30 days following the emergency repair of AAA. The most significant results found are;

- Systolic Blood Pressure less than 70 mm of Hg caused higher mortality. P – Value < 0.002
- Haemoglobin less than 8 gm/dl caused higher mortality. P – Value < 0.005
- Serum creatinine level over 150 u mg/l caused higher mortality. P – Value < 0.055
- Age over 80 years has higher mortality as compared to the age group less than 80 years. P – Value < 0.043

Conclusion

We suggest that any patient who arrives in the emergency department with a blood pressure lower than 70 mm of Hg, haemoglobin less than 8 gm/dl, age over 80 years and creatinine over 150 u mol/l has a lesser chance of surviving the operation. These variables can be used as a predictor for mortality of rupture AAA. The advanced endovascular technique should be adapted by all vascular surgeons to perform repair of ruptured AAA as a routine to reduce mortality.

Table 1 - Association between Haemoglobin Less or Over 8gm/dl and Mortality

Chi-Square Tests

	Value	df	Asymp.Sig (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.474 ^b	1	.004		
Continuity Correction ^a	6.091	1	.014		
Likelihood Ratio	10.751	1	.001		
Fisher's Exact Test				.005	.005
Linear-by-Linear Association	8.272	1	.004		
N of Valid Cases	42				

a. Computed only for a 2x2 table b. 2 Cells (50.0%) have expected count less than 5. The minimum expected count is 2.71.

Table 2 - Association between Low Blood Pressure and Mortality

Chi-Square Tests

	Value	df	Asymp.Sig (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	9.842 ^b	1	.002		
Continuity Correction ^a	7.807	1	.005		
Likelihood Ratio	10.378	1	.001		
Fisher's Exact Test				.002	.002
Linear-by-Linear Association	9.607	1	.002		
N of Valid Cases	42				

a. Computed only for a 2x2 table b. 0 Cells (0.0%) have expected count less than 5. The minimum expected count is 5.43.

Table 3 - Association between Age and Mortality

Chi-Square Tests

	Value	df	Asymp.Sig (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.546 ^b	1	.033		
Continuity Correction ^a	3.167	1	.075		
Likelihood Ratio	4.628	1	.031		
Fisher's Exact Test				.043	.037
Linear-by-Linear Association	4.438	1	.035		
N of Valid Cases	42				

a. Computed only for a 2x2 table b. 1 Cells (25.0%) have expected count less than 5. The minimum expected count is 4.98.

Table 4 - Association between Serum Creatinine and Postoperative Mortality

Chi-Square Tests

	Value	df	Asymp.Sig (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.896 ^b	1	.027		
Continuity Correction ^a	3.367	1	.067		
Likelihood Ratio	5.046	1	.025		
Fisher's Exact Test				.055	.033
Linear-by-Linear Association	4.779	1	.029		
N of Valid Cases	42				

a. Computed only for a 2x2 table b. 2 Cells (50.0%) have expected count less than 5. The minimum expected count is 4.07.

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Influence of Duration of Acute Symptoms and Distance Travelled on the Outcome of the Repair of Ruptured Abdominal Aortic Aneurysm

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Introduction

To find out if the duration of acute symptoms and the distance travelled to vascular unit causes any adverse effect on the outcome of the repair of a ruptured abdominal aortic aneurysm (AAA). Abdominal aortic aneurysms are an increasingly common condition in Western countries. Over the last three decades, the incidence has tripled, which may reflect the increasing age of the population and improvements in diagnostic methods.^(1, 2) Only 40 to 50% of patients with a ruptured abdominal aortic aneurysm survive to receive hospital treatment, and the peri-operative mortality rate approaches 50%.³ However, with a ruptured aneurysm and emergency repair, the mortality rate rises to about 75%.⁴

Methodology

Retrospective review of records of all of the patients with ruptured abdominal aortic aneurysm (AAA) operated upon in our unit between April 1996 and March 2001. Demographic and clinical data were collected. Specifically, duration of symptoms and distances travelled were noted. Appropriate statistical analyses were performed.

Results

42 patients (37 males and 5 females) had an operation for ruptured (AAA). The 19 patients who died (45%) had travelled 21.84 \pm 20.36 miles and 23 patients who survived (55%) had travelled 19.35 \pm 17.27 miles. There was no statistical difference with P-Value = 0.67. Those who died had acute symptoms for 34.4 \pm 35.5 hours and those who survived had acute symptoms for 19.8 \pm 17.4 hours, P-Value = 0.34 not significant statistically.

Conclusion

Duration of acute symptoms and distance-travelled up to 50 miles does not affect the operative mortality for ruptured AAA. We recommend transfer of patients after early diagnosis and resuscitation to a vascular unit irrespective of duration of symptoms and distance.

Table 1 - Independent Samples Test

		Levene's Test for Equality of Variances				t-test for Equality of Means			95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Distance in Miles	Equal variances assumed	2.085	.156	.430	40	.670	2.49	5.805	-9.238	14.227
	Equal variances not assumed			.423	35.504	.675	2.49	5.898	-9.474	14.462

P-value = 0.67 Not statistically significant

Table 2 - Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
								95% Confidence Interval of the Difference		
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Distance of Symptoms hours	Equal variances assumed	2.292	.138	.945	40	.350	243.05	257.084	-276.539	762.635
	Equal variances not assumed			.878	22.058	.390	243.05	276.953	-331.229	817.325

p-value = 0.350 Not statistically significant

Presented

As a poster presentation at The Sylvester O'Halloran Surgical Scientific Meeting in the University of Limerick on March 5th and 6th, 2004.

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Audit on Non-Attendees and On-Day Cancellations in a Regional Based ENT Unit

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Introduction

There is a notable number of postponed or cancelled routine scheduled procedures in any surgical service. Published data has shown that non-attendance for routine surgery costs the NHS between £88 and £266 million per annum.

Rationale

This audit serves to identify reasons for non-attendees and on-day theatre cancellations and thereby attempts to decrease avoidable causes.

Methodology

This audit was carried out from September 2003 to December 2003. Patients that were non-attendees or cancelled on the day of the operation were contacted by mail or telephone. Cancellation notices of more than 24 hours were excluded from the study. Chi-Square Test was used to analyse data.

Results

A total of 413 operations were scheduled during the period of the audit. Three hundred and sixty four patients underwent surgery. Twenty five (6.0%) of patients did not have their scheduled operation of which 16 patients did not attend without any notification and 9 patients had on-day cancellations. The reasons for not having surgery are presented in Table 1. Age of patient was not significant. Septoplasty surgery was associated with more non-attendees and cancellations ($p=0.004$) and statistically significant ($p=0.022$) when patients not having an operation were tested against those who had an operation.

Conclusion

The cancellation rates in this unit are low as compared to data provided by other published studies. A one-year prospective audit (Hampal, Flood; *Clin Otolaryngol* 1992, June) showed 5% did not attend without any notification to the hospital. In our ENT unit, this figure was 4%. Most causes identified in this audit were avoidable. Therefore better theatre space utilization can be expected with improved communication between the hospital and the patient.

Table 1 - Reasons for Non-Attendance/Cancellations

Reasons For Non-Attendance/Cancellations	Frequency	Percent (%)
No/Late notification	5	1.2
Change of address	3	0.7
Work/Study related	10	2.4
No hospital bed	3	0.7
Illness	11	2.7
Unable to contact	8	1.9
Miscellaneous	9	2.0
TOTAL	49	11.6

“A Man’s Best Friend?” A Six-Year Retrospective Analysis of Facial Lacerations as a Result of Dog Bites in the Mid-Western Health Board Region

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Introduction

For the period 1998 to August 2004 fourteen children were treated by the Oral and Maxillofacial Department, in the Mid-Western Regional Hospital for facial lacerations sustained from attacks by dogs. This is a retrospective analysis of those patients.

Rationale

This is an epidemiological review of facial dog bites treated by the Oral and Maxillofacial Surgery Department in the Mid-Western Health Board.

Methodology

Fourteen patients were identified from the database for the period 1998 to August 2004 as having received lacerations to the face as a result of dog bites.

The following information was investigated;

Age of patient, site of laceration, aetiology of injury, location of injury (home etc.), associated injuries, tetanus status, length of time between admission and treatment, treatment in theatre, antimicrobial therapy, whether treatment was performed out of hours or on regular theatre lists, length of stay in hospital, follow-up appointments and need for scar revision.

Results

The study population was fourteen. The average age was three with an age range of 2-9 years with 64% of children being younger than 5 years. Females were involved in 64% of cases. Commonly these wounds involved a number of sites on the face, with 65% involving the lips, 28% the eyebrows and the remainder involving the cheeks, forehead and chin. Over 50% of patients had multiple lacerations and puncture wounds to the face. There was no other soft tissue or bony injury as a result of these attacks.

Just over 50% of these incidents occurred in the family home. Two of the attacks were on the street and two were at the children’s grandparents. 71% of the attacks were by either the family pet or dogs known to the patients.

Tetanus status was investigated in all cases following presentation to the Accident and Emergency Department and only one child required a booster dose.

The time between admission to hospital and theatre ranged from 1.5 hours to 13 hours with an average waiting time of six hours.

Debridement and primary closure of the lacerations under general anaesthetic was performed. All patients received intravenous antibiotics. Chloromycetin ointment was applied to the wounds from the first postoperative day. All patients were discharged on oral antibiotics and chloromycetin ointment.

86% of these cases were performed in theatre out of hours with just two cases being added to the routine Oral and Maxillofacial theatre lists.

42% of patients attended for three follow up appointments prior to discharge, 2 patients did not attend for follow up and the remainder were seen twice prior to discharge. None of the patients underwent scar revision.

Conclusion

Young children can quite commonly sustain lacerations to the face as result of a dog bite. Prompt presentation and treatment is recommended to enhance the postoperative surgical result and decrease the level of psychological trauma for both patient and carer.

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An Audit of Laparoscopic Cholecystectomy without Routine Intra-operative Cholangiography in a General Hospital

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Introduction

This study evaluated the selective use of endoscopic retrograde cholangiopancreatography (ERCP) in the context of Laparoscopic Cholecystectomy (LC) for dealing with Common Bile Duct (CBD) stones while minimizing the use of operative Cholangiography.

Methodology

Retrospective data were collected on 139 patients undergoing LC at Nenagh General Hospital. Preoperative indications for ERCP were recorded, radiologic findings were standardized and technical points for safe LC were explained.

Results

Of the 139 patients described, 17 patients were thought to be at preoperative risk for a CBD stone and, as a result, underwent preoperative ERCP. Indications for ERCP included a history of jaundice (10.9%) or pancreatitis (22%), the presence of one or more abnormal liver function tests (87%), and the presence of a dilated CBD (15.2%) or the demonstration of choledocholithiasis on preoperative ultrasonography (3.2%). Only two patients went for Intra-Operative Cholangiography (IOC).

Conclusion

LC can be performed safely without routine IOC. The selective use of preoperative and postoperative ERCP will deal with the CBD stones in 92% of patients.

An Explorative Study into the Expansion of Nursing and Midwifery Roles in Response to the European Working Time Directive

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Introduction

The Nursing and Midwifery Planning and Development Unit (NMPDU) of the Mid-Western Health Board (MWHB) commissioned a report to explore the possibilities for role development opportunities for nursing and midwifery services in the MWHB region in light of the forthcoming European Working Time Directive (EWTD).

Rationale

The study was undertaken at the request of the Chief Nursing Officer of the Nursing Policy Division in the Department of Health and Children to examine opportunities for nurses and midwives, identify the supports required to develop new services along with resource implications and finally the impact on quality of patient care.

Methodology

Quantitative research methodology using focused group interviews was employed as a method of data collection. A representative sample of 15% of nurses and midwives of all grades working within the acute sector were interviewed to ascertain their opinions, proposals and comments regarding opportunities for professional enhancement and development. A brief introduction was conducted prior to questioning with the content of the interview broadly based on the Scope of Practice for Nurses and Midwives.¹ Following the presentation attendees were asked to focus on five broad areas as follows:

- Areas of practice that could be expanded
- Identification of existing gaps in the service
- The skills and knowledge required to fill the gaps
- The appropriate personnel to fill the gaps
- The educational and support structures required to expand practice

Open-ended questioning was used, and in the interest of assuring validity, information gathered was summarised with participants at the end of each session.

Results

The results indicated that the vast majority of participants were willing to consider expanding their practice for the betterment of patient/client care and service delivery. A notable finding of this report is the assertion that practice developments of this magnitude could not realistically be achieved within current working practices and that appropriate structures would need to be in place prior to practice enhancement initiatives. The structures highlighted by participants were common to all disciplines and came under the following broad categories:

- Skill mix
- Education
- Support structures

Each discipline indicated how these categories could be developed to suit their service delivery. The key success factors for the planning and implementation of the proposals in this report should involve change, leadership and partnership.

Conclusion

Participants of this study have demonstrated their continued commitment to professional development and quality care delivery. They indicated their willingness to embrace opportunities to re-evaluate the service they offer to patients/clients and their families in the sure understanding that the initiatives proposed by participants in the focus groups will lead to better utilisation of their professional expertise and knowledge resulting in a more efficient, streamlined and seamless service.

Presented

At the National Council Conference in Dublin on November 19th and 20th, 2003 by Ms. Nora Irwin O'Rourke and Ms. Lorna Peelo-Kilroe.

Reference

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Introduction

Vomiting in early pregnancy is very common and when excessive and persistent results in admission to hospital. This can have a significant impact at personal, social and organisational level. In severe cases hyperemesis gravidarum is diagnosed and if inadequately or inappropriately managed it can be associated with significant complications such as Mallory-Weiss oesophageal tears, Wernicke's encephalopathy, central pontine myelinosis and maternal death.

We wished to evaluate the management of and outcome of pregnancy in women requiring admission to hospital because of vomiting in early pregnancy.

Rationale

To evaluate management and outcome of pregnancies associated with significant vomiting in early pregnancy

Methodology

We identified women who were admitted to hospital because of vomiting in early pregnancy during the seventh month period from December 2002 until June 2003 inclusive. Their case notes were reviewed and data extracted pertaining to patient characteristics, clinical management and outcome of pregnancy.

Participants included 50 women requiring admission to hospital for the management of vomiting in early pregnancy.

The main outcome measures were:

- (a) The length of hospitalization/readmission
- (b) The treatment given
- (c) Pregnancy complications
- (d) Pregnancy outcome

Hyperemesis gravidarum was defined as persistent vomiting with severe ketonuria (+3) after exclusion of urinary tract infection or other non-pregnancy related causes.

Results

Length of hospitalisation varied from 1 to 25 days. 40% of cases required readmission. 62% of patients had rehydration with intravenous fluids alone while 19/50 had intramuscular antiemetic therapy. 4/50 (8%) were treated with corticosteroids. 6 women had urinary tract infections while 11(22.9%) had delivery by caesarean section. Of the 48 babies delivered, 2 were pre-term. 24 babies had birth weight \leq 50th centile with 3 (16%) weighing \leq the 10th centile for gestational age. 10 births were $>$ 90th centile.

Conclusion

Vomiting in early pregnancy requiring hospitalisation has a significant impact at a personal, social and organizational level. Maternal and perinatal outcome was favourable in this group.

Presented

As a poster presentation at the Irish Perinatal Society Meeting in Cork on April 24th, 2004 by Dr. Lubna Jamal Qureshi.

A Study of Patient-Controlled Benzodiazepine Dose Reduction in a Generic Community Mental Health Service

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Introduction

We report a patient-controlled benzodiazepine discontinuation programme in a generic multidisciplinary community mental health service.

Methodology

An audit of prescribing identified baseline benzodiazepine use and stimulated a discontinuation programme that included an evidence-based prescribing policy, psychoeducation and anxiety management to encourage benzodiazepine cessation. Benzodiazepine status was reassessed at 12 and 24 months follow-up.

Results

158 patients were receiving benzodiazepines at the study onset. At 12 month follow-up benzodiazepine use was substantially reduced (n=68) due to discontinuation (n=32), dose reduction (n=26) and service dropout (n=71). Benzodiazepine status at follow-up was predicted by attendance at anxiety management sessions ($P<0.01$) and shorter duration of benzodiazepine use ($P=0.03$). Discontinuation followed four main patterns: (a) rapid and complete discontinuation (n=19); (b) total discontinuation in a gradual manner (n=13); (c) partial dose reduction without total discontinuation (n=18); and (d) almost total discontinuation but could not totally stop completely (n=8). The patients that achieved total discontinuation tended to be younger and in receipt of benzodiazepine agents at lower doses and for a shorter duration. At 24 month follow-up only 3 patients had relapsed into benzodiazepine use and a further 13 had achieved total discontinuation.

Conclusions

A substantial proportion of chronic benzodiazepine users can achieve lasting discontinuation through patient-controlled dose tapering. Patient refusal and service dropout are commonly encountered during discontinuation programmes. Anxiety management is a valuable adjunct to discontinuation.

Introduction

The National Health Strategy, *Quality and Fairness: A Health System for You*¹ emphasises the need for more accurately planned evidence based services. The *National Health Information Strategy*² indicates that whilst progress has been made in improving information systems in the health sector many significant health information deficiencies exist. The *Mental Health Commissions Annual Report*³ states that there is “wide variability in the information management capabilities of mental health services” and emphasises that the availability of timely, accurate and complete information is essential to provide and plan a quality mental health service.

Information on mental health problems in Ireland is routinely gathered through two reporting systems i.e., the National Psychiatric In-Patient Reporting System (NPIRS) and the Psychiatric Case Register⁴. NPIRS records information on first admissions but does not measure clinical outcomes. The case register is person-based rather than event-based. Neither system measures clinical outcomes. For example, the present system provides little information on unmet need of carers, gaps in the services provided or outcome measures. There is a strong need to improve the quality of information on patients and treatments delivered, if the service is to develop in a way which is responsive to community needs.

Rationale

The electronic patient information system, the Functional Analysis of Care Environment (FACE) system, is a recording and measurement technology designed to integrate clinical and management information allowing patient assessment and outcome recording. The software includes assessment and outcome measurement toolsets which enables interactive graphical outcomes reporting as well as coding software which assesses the severity of the patient’s symptoms and behaviours on a 5 point severity scale, thereby generating high quality information about patients which facilitates data analysis⁵. See Table 1. This study evaluated the FACE system within a mental health service for older people based on the following criteria:

- usability of the FACE system
- quantity and quality of information available to clinicians
- impact on clinicians of using the FACE system
- measurement of clinical outcomes.

Table 1 - Five Point Severity Scale

+	I	No problem
+	I	Mild problem
-	I	Moderate problem
		Depressed mood is clear, present more often than not, tearful at times, causing significant interference in daily functioning. Ideas of guilt, self-blame, worthlessness.
+	I	Severe problem
+	I	Very severe problem
-	I	Not known
-	I	Not applicable

Methodology

A networked web-based version of the FACE software was installed on seven personal computers, which were networked to a secure central Health Board server with back up facilities. A qualitative and quantitative study design was used to evaluate the FACE system which consisted of two samples – clinicians and patients. The usability and impact of the FACE system on clinicians was assessed through analysis of staff questionnaires using the statistical package for social sciences (SPSS) and one to one discussions with staff at three intervals. The quantity and quality of information generated by the FACE information system was evaluated by comparing the FACE system with the existing recording system through the collection and analysis of patient data, including follow-up data, using the FACE software (n=76).

Results

Findings from analysis of staff evaluation questionnaires reveal that the FACE assessments, in either paper or electronic format are user-friendly with at least 80% of respondents finding the system easy to use. Following the use of the electronic version 9 (81%) of staff agreed or strongly agreed that the system provided better quality information. At the three time points most of staff found that the introduction and implementation of the FACE system to staff was effective with 1 (11%) at time 1 and 1 (9%) at time 2 undecided and no negative responses were given. Opinion is divided on the value of the FACE system in improving clinical practice. 7 (77%) are still undecided or disagree at time 1 and 8 (72%) are still undecided or disagree at time 2. Staff suggestions stated concerns about the time factor of completing assessments, duplication of work and compatibility with standard mental health forms. However, the potential of the FACE system was clearly demonstrated by all staff in the final evaluation (time 2) calling for its continued use with 64% of staff suggesting its continued use with improvements in some aspects of the system, such as recording of personal and family history, case summary, reason for change of medication, results of investigations and patient care plan.

A comparison of information was carried out and it was found that the FACE system provides clinicians with information that is easy to retrieve and analyse. See Table 2.

Table 2 - Comparison of Information Systems

Information collected by each system	
<u>Current Recording System</u>	<u>FACE System</u>
<ul style="list-style-type: none"> • Patient Registration Details • Clinical Information <ul style="list-style-type: none"> - Presenting Complaint - Relevant History e.g. Psychiatric, Medical, Family, Personal, Legal. - Medication - Mental State Examination - Records social, occupational, interpersonal functioning, self care and case formulation <p>None of these dimensions are graded</p>	<ul style="list-style-type: none"> • Patient Registration Details • Clinical Information <ul style="list-style-type: none"> - Mental Health - Cognitive - Behaviour - Activities of Daily Living - Physical Well being - Social Support - Risk - Medication - Mental State Examination Score <p>Each of these dimensions are graded by severity Changes over time can be qualified leading to outcome measures</p>

The FACE system provides

- Measurement on individual health needs, health service needs, risk and clinical outcomes
- Prioritisation of service needs
- Demographic information and comparison of diagnostic groups
- Statistics on at risk patients by category
- Graphical representation of individual or patient groups' progress over time
- Changes over time can be quantified leading to outcome measures

Conclusion

The FACE system is user friendly and provides better quality data compared to the current system. Analysis from patient data shows that the FACE system can prioritise service needs, identify and compare diagnostic groups and plot progress over time. Results indicate that the FACE system provides better quality information including clinical outcomes, thus assisting in both individual patient decisions and planning future service development. The FACE system clearly has potential; however, improvements are needed in some aspects of the system.

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Audit of Meal Provision for Dysphagic Patients

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Introduction

Failure to provide the body with adequate nutrients, or malnutrition, causes a number of effects within the body for example, impaired wound healing, decreased resistance to infection, muscle wasting and longer length of hospital stay. Appropriate nutritional support and adequate intervention can reduce the risk of the complications and help to reduce morbidity and mortality. Inadequate food intake among hospitalised patients may be a consequence of poor health or special needs of an individual, or as a result of poor standards set for caterers. Dysphagic patients are individuals that have difficulty swallowing normal food. They require a diet of modified consistency that is either soft, puree or liquid in nature, dependant on their swallowing ability.

Objectives

1. To assess the nutritional content of meals provided to patients who require pureed consistency.
2. To establish current catering practices and identify areas where the nutritional value of the meals provided may be sub-optimal.

Methodology

All staff employed in the kitchens were asked to complete a questionnaire to identify current practices. Quantities of each ingredient added to puree meals were then analysed using McCance & Widdowson's 'Composition of Foods' (6th ed.), to review the kilocalories and protein content. Variances in recipes used by different staff members were requested in order to assess the difference in nutritional values of the most common meals prepared.

Results

Table 1 shows the range and average analysis of kilocalorie and protein content of recipes for commonly used puree meals per 300ml serving.

Table 1 - Analysis of meals per estimated 300ml portion

Dinner type	Kilocalories	Protein g
Bacon with white sauce	250	24
Beef /chicken with gravy	120-250 average 193	10-17 average 13.5
Fish with white sauce	264-360 average 307	24-32 average 26.5
Fry-up with tea/milk	340-400 average 395	24-33 average 26
Sandwich +/- Milk	145-251 average 215	9-25 average 15
Beans on toast with tea/sauce/milk	169-300 average 220	9-19.5 average 15

Table 2 - Sample meal plan and analysis of kilocalorie and protein intake if full meals eaten.

Meal	Kilo Calories	Protein g
Cereal e.g. porridge with hot milk and sugar, cup of tea with milk and sugar Orange juice - 100mls	324	7
Soup, puree dinner, fruit puree, cup of tea, glass of milk	532	24
Puree milk dessert for tea time, cup of tea	242	8
Cup of tea mid-morning and bedtime (with milk and sugar added)	124	2
TOTAL	1,222	41
% nutritional requirements achieved if full puree meals eaten by a 70kg man	66%	58%
% nutritional requirements achieved if full puree meals eaten by a 64kg woman	<75%	66%

Discussion & Conclusion

During the initial stages of their recovery post stroke, most dysphagic patients do not manage to eat the full puree meals provided, it is also noted that their nutritional requirements are much higher than normal during this recovery period. Figures noted at ward level indicate that many patients eat smaller amounts of puree meals and may not have the soup or dessert options. This means that the estimated nutritional intake, from the sample puree diet in Table 2, is likely to be much less than 66% for an average elderly man (weight 70kg), or less than 75% for an average elderly woman (weight 64kg).

Recommendations

1. Catering committee.
2. Education of support staff about the importance of nutrition in relation to disease therapy.
3. Implementation of food moulding and fortification of puree diets provided.

References

Available on request

Introduction

Improvements in life expectancy due to modern medical treatments and higher standards of living have demonstrated that older members of our society are surviving much longer.¹ Many Health Boards including the Northern Area Health Board have piloted a variety of service developments with a projected increasing ageing population. These projects require evaluation.

Rationale

This research addresses the importance of obtaining consumer views of a unique new service that enables heavily dependent patients to remain at home through a multi-agency integrated partnership co-ordinated by a care organiser.

Methodology

A semi-structured interview was utilised to facilitate this cross-sectional study design. The home first questionnaire designed by the researcher with support from those providing the service was demographic in content. The Mini-Mental State Examination (MMSE)² scale, the Hospital Anxiety and Depression Scale (HAD)³ and the quality of life scale (SEIQoL)⁴ were completed during each interview if the older person was well enough (N = 28). Families contributed to the Home First questionnaire which supported the older person and enhanced the research findings. All interviews were carried out in the home setting. Analysis was conducted utilising the statistical package Data Desk.

Results

Results clearly identify that this client group are delighted with services of the Home First Programme despite a number of issues that need addressing at operational level. The route of referral is significant with reduced opportunities for those in the community to access the Home First Programme due to delay in accessing a geriatric assessment at hospital level. The ability to access day hospital facilities would not only respond to client needs but also provide a cost effective method of service provision. The role of the care organiser is pivotal in planning services where patients are hospital based. However there is a requirement for a community based care organiser to further this service development.

Conclusions

Recommendations from this study include the need for more consumer surveys to evaluate what services older people value. A number of home subvention schemes/packages of care already in place require analysis and comparison to the Home First Programme in order to clarify effectiveness and cost value. Nationally there is a need to share information by collating and evaluating individual initiatives collectively.

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Funding

This research was partially funded by the Northern Area Health Board and by the East Coast Area Health Board.

Introduction

Increasing demands for accountability, access, improved quality of health care and better cost management are driving the development of external peer review mechanisms.¹ Accreditation is a self-assessment and external peer review process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system.² Continuous quality improvement is the pivotal reason for participating in accreditation.

The Mid-Western Health Board applied for Accreditation in November 2002 to partake in an internationally recognised quality system and enable it to develop a quality system for the five Acute Hospitals in the region, which would facilitate staff in providing the best level of care to the patient.

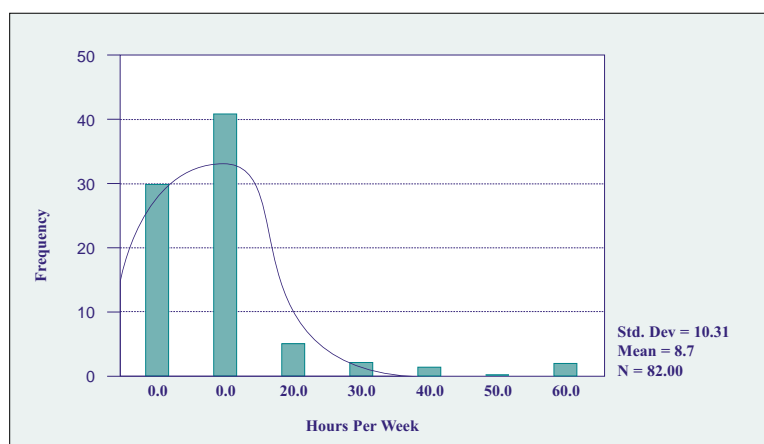
Rationale

The aim of this research study was to evaluate the experience of self assessment from the perspective of the staff involved in the accreditation project, to ascertain the benefits to be gained in engaging in this particular self assessment process and the lessons the organisation could learn and carry forward in participating in future accreditation programmes.

Methodology

An analysis using both quantitative and qualitative methods of enquiry was initiated. A particular focus was placed on the individual's experience of accreditation through the grounded theory method. Three senior managers were interviewed followed by a focus group of eight staff. Questionnaires were sent out by group e-mail to all 17 self-assessment teams with a response rate of 33%.

Table 1 - Hours per week spent preping the self assessment manual



Results

The main benefits to be derived from the experience were staff learning and development, communication and networking, team building, the evaluation of services and the development of quality, patient focused systems and processes. The time consuming nature of the project was the principal criticism directed at the process.

Conclusions

Accreditation can be used by management as a tool for organisational and cultural change given the participation of everyone in the organisation. This initiative presents a means of implementing a continuous quality improvement process within the organisation, and demonstrates to our stakeholders that good practice is being followed.

Recommendations

Recommendations were made around leadership, training and team selection processes as part of moving forward with this quality programme.

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Funding

This research was partially funded by the Mid-Western Health Board.

Introduction

Needs Assessment has appeared both explicitly and implicitly, as a concept central to past and present UK Government policy and appears repeatedly in statements of health and social policy. It is seen as an approach that underpins both good commissioning and good clinical practice at patient level. Its importance is widely recognised and the method widely used to inform service planning and development. However, *Cohen and Eastman, 2000* observe that the degree of success (in using this approach) has been of varying standard.

Rationale

The Forensic Mental Health Services of East London have, over the years, used HNAs to support service developments to varying degrees of success. A need was identified to examine the experience of the service and compare this to the existing knowledge in the field to see what lessons could be learnt.

Methodology

A qualitative research methodology was used to carry out the study.

Secondary data was obtained through examination and analysis of archival material relevant to the service setting, health needs assessments and government policy documents.

Primary data was obtained using a combination of guided conversations and semi-structured interviews with commissioning managers, service management and clinicians that have been involved in conducting HNAs.

Results

Stimulus for the commissioning of the needs assessments were:

- government policy: reduce reliance on private sector provision and out of area placements
- political imperative: public safety and media interest
- availability of new money/resources
- influential personalities at local and regional level

Selection of methodology

- selection of methodology was influenced by the time available to conduct the study and a very influential personality at local level

Time factor

- time scale for production of the report was very short
- no protected time was allocated to the needs assessment team to conduct the study
- very long time lapse between undertaking the study and feeding its findings into the service planning process

The conduct of the health needs analysis was value-laden and fraught with subjectivity.

Conclusions

- The use of HNA by the East London Forensic Mental Health Services in developing services for MDOs, significantly, mirrors what is written in existing literature and current research findings.
- The use of HNAs within such services is a complex and difficult task but the body of knowledge in this high profile area is currently limited.

Recommendations

- Adequate training needs to be provided for personnel assigned to conduct HNAs.
- Adequate resources need to be provided to support the undertaking of HNAs.
- Further research should to be undertaken in the area of HNAs for the development of services for MDOs to help planners, managers and clinicians alike in their quest to develop appropriate, seamless and responsive services for this challenging patient group.

Presented

At “Health Needs Assessment - Its Role in Policy and Planning” in the Institute of Public Administration, Dublin, on September 24th, 2004 by Mr. Magnus Conteh.

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Pilot Study of a Tool to Investigate Perceptions of Family-Centered Care in Different Care Settings

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Introduction

Family-centered care (FCC) is widely used in paediatrics, but its applicability in all areas of paediatric care is little studied.

Rationale

This study, based in Australia, aimed to develop and trial a tool to compare parents' and staff's perceptions of FCC in inpatient versus outpatient areas, hospital versus community, public (non-fee paying) versus private, areas with acute versus chronic admissions, and those with short-term versus long-term hospitalisations.

Methodology

Based on two questionnaires used to examine concepts of FCC,^{1,2} and using structured interviews and content analysis, a tool was designed which was subjected to rigorous validity and reliability testing. It was trialed with samples of 10 parents and 10 staff in each of the care areas.

Results

The tool was found to effectively elicit valid responses which could be easily analysed. Some data analysis was undertaken and significant results found. However, because of the small sample sizes, few conclusions could be drawn.

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The Practical Implications of a *Clinical Confidence* Table in Predicting Malignant Breast Disease

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Introduction

Referral of patients to the symptomatic breast clinic will include women with benign and malignant disease, the “worried well” who may have positive family history for breast cancer and are eager to be “screened”. The referring doctors to our breast clinic were advised to predict the likelihood of a choice of diagnosis. An estimate of their *clinical confidence* in the diagnosis as:

- Possible less than 0.6
- Probable less than 0.9
- Certain more than 0.9

was required on the pro-forma referral letter.

An episode of care for each patient was opened on the date we received the letter. More urgent cases were seen in the clinic on the next week, while requests for screening and less urgent cases were referred to the radiologist or back to the G.P. The purpose of this report is to assess the usefulness of *clinical confidence* scoring in patient triage.

Methodology

643/1,200 patients' referral letters were reviewed for the period 1st January 2000 to 31st October 2001. Triage to: 1) Clinical consultation only, 2) Clinical consultation and mammography, 3) Direct to mammography and no breast clinic consultation, was used. We adopt the Null Hypothesis and assume that the use of the *clinical confidence* table in the letter makes no difference.

Results

69 (21.5%) were marked as malignant, none of these had cancer. 324 (50.3%) pro-forma letters gave no indication of any clinical diagnosis, 7 (2.1. %) of these had cancer. Of 284 (88.5%) letters marked as benign or normal, 3 (1.05%) had cancer. (40 cancers were detected in the remaining handwritten letters).

Conclusion

Compliance in using the *clinical confidence* table was poor (50%). Presence of cancer did not correlate to the clinical estimate on the *clinical confidence* table.

Medication Education of the Older Person

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Introduction

The lack of structured medication education of the older person can result in patients having difficulties managing their own prescribed medications on discharge from hospital. Such problems highlight a need for structured educational sessions with the patient/carer.¹ In March 2004, after education sessions with the multidisciplinary team a medication education programme was implemented in the Stroke/Rehabilitation Unit at St. Camillus' Hospital.

Methodology

Twenty-five patients were selected over a six-month period by nursing staff using an assessment form based on criteria, such as patient discharge destination, consistency of medications, and patient history. The patient's baseline knowledge of their prescribed medication was recorded in a pre-audit document. Written information of the patients' medications is completed on a medication record card. The nurse performs the individualised education programme for the patient with the prescribed medications supported by written information and verbal counselling. A post-audit form is completed prior to discharge.

Results

The number of patients who could name or identify all their prescribed medications increased from 42% to 75%. In addition, the number of patients who knew the correct quantity of medications to take increased from 38% to 79% while those who knew the correct time to take their medications increased from 38% to 94%.

Conclusion

These results highlight the success of the programme in educating patients about their medications. The programme has also highlighted other issues such as eyesight and dexterity problems. These indirect benefits combined with the overall improvement in patient knowledge of medications clearly indicate the importance of this programme in patient care.

Presented

1. At the 1st Annual Conference "Celebrating the Nursing and Midwifery Contribution to Health Gain in the Mid-West Region" in Bunratty, Co. Clare on April 22nd, 2004 by Ms. Noreen Wall.
2. As a poster at the National Council's 4th Annual Conference 2004 "Facing the Challenge of Change: Nurses and Midwives – Proactive in Professional Development to Support Change" on November 17th, 2004, in Dublin.

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Introduction

Documentary is an innovative and effective method of presenting qualitative enquiry.

The Palliative Medicine Department in Limerick has acquired considerable experience in qualitative research including traditions of death and dying in the West of Ireland, in the West of Scotland and more recently the analysis of the moment of death for people within a Palliative Care Unit and/or dying at home. The outcome of these qualitative enquiries has been presented in documentary format.

There is little appropriate material in a multi-media format on the issue of children's bereavement. Children's bereavement services in Ireland utilise material produced in the United States and other English language countries.

Rationale and Methodology

The purpose of this documentary is to produce material on the issue of children's bereavement appropriate to Irish culture. This project has been partially sponsored by the Irish Hospice Foundation, who had already noted the absence of culturally specific material for an Irish audience on this issue. The purpose of the documentary will be as a teaching resource both for adult and children's audiences. The adult voices in the documentary will be reduced to a minimum, i.e., voice-over. All visual material will be of children telling their story of how they live with grief following the death of a parent, both parents and/or friends. The documentary will be filmed in the Mid-West and wholly produced in the Mid-West.

Results

Following its production, an appropriate set of facilitator notes and companion material will be added to form a teaching pack. The Mid-Western Health Board has promised to support this innovative project financially.

Funding

This research has been partially funded by The Irish Hospice Foundation.

Oral Assessment and Intervention Tool

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Introduction

Oral hygiene is a vital component of holistic care given to patients and delivery of oral care is often neglected and given low priority.^{1,2,3} Oral care practices have often remained rooted in tradition and ritual rather than based on sound evidence or research.^{4,5} In 2002 an internal audit using Q.U.A.S.A.R. (Quality Assurance Survey Tool) examined nursing documentation of patient assessment on admission to the Stroke/Rehabilitation Unit. Results of the audit supported existing research.

Rationale

The Q.U.A.S.A.R. audit highlighted the need to record the presence and condition of the patients' teeth or dentures. This prompted the authors to review the literature, examine current practices and design an Oral Assessment and Intervention Tool in relation to the care of the older person.

Methodology

A literature review was undertaken using Medline, CINAHL and a manual search. The lack of nursing documentation led to the development of an Oral Assessment and Intervention Tool. Nursing staff and members of the multidisciplinary team engaged in educational sessions to facilitate the introduction of the Tool. A case study has been completed which demonstrated the holistic benefits of the tool in oral care.

Results

In April 2004 the Oral Assessment and Intervention Tool was implemented as part of the nursing assessment for all patients admitted to the Stroke/Rehabilitation Unit. In August 2004 a repeat of the Q.U.A.S.A.R. audit showed significant improvements. There was a 66% improvement in documenting the presence of patients' teeth or dentures and 67% improvement in indicating the condition of patient's teeth or dentures. A review of the tool and its design is planned in October 2004.

Conclusion

The mouth plays an important role in body image, eating, drinking, taste, communication and breathing and thus it deserves the total ongoing commitment of the multidisciplinary team. Our findings recommend that Oral assessment needs to be an integral part of the nursing admission. The introduction of an assessment and intervention tool with clear guidelines assists in the implementation and documentation of oral hygiene.

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Introduction

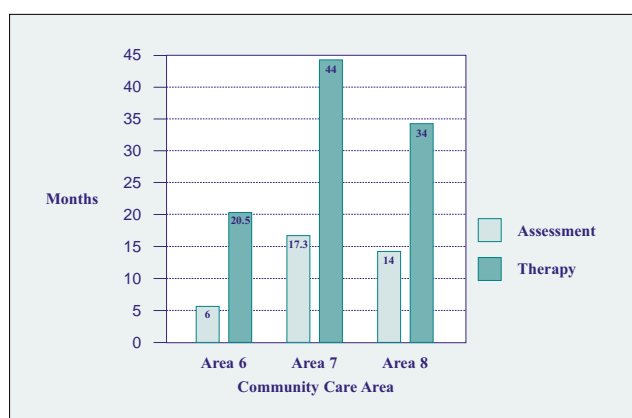
Speech and Language Therapy (SLT) is the health care profession specifically concerned with the assessment, diagnosis and management of those who have speech and/or language impairments. Speech and language impairment is one of the most common types of disorders in childhood (Beitchmann, Brownlie and Wilson, 1996). Johnson, Beitchmann, Young, Escobar, Atkinson, Wilson, Brownlie, Douglas, Taback, Lam and Wang: (1999) state that young children who have speech and language difficulties are at risk for continued communication problems as well as for associated cognitive, behavioural, social and psychiatric difficulties. Language impaired children are also at high risk for learning difficulties and consequently behavioural problems may develop as a result of the difficulties these children experience in academic settings.

Timely assessment and intervention is crucial in reducing the long-term implications of speech and language impairment.

Community Care SLT is a primary care service that aims to offer timely assessment, early intervention, health promotion and onward referral to other services if appropriate.

By December 2002, it had become increasingly challenging to achieve these aims due to the increasing demand placed on the service and significant recruitment and retention issues as evidenced by the following waiting times:

Table 1 - Waiting Times 2002



Rationale

In order to address the significant challenges facing the service, we identified the following objectives for the SLT Waiting List Initiative:

- To improve timely access to SLT services
- To provide an equitable service
- To reduce waiting times without affecting the quality of the service provided
- To develop a partnership with parents/caregivers in therapy

The new model of service delivery adopted to meet these objectives was an Australian Model, the Maroondah Approach to Clinical Services (MACS) as:

- It was developed within an outpatient community SLT setting
- It improves waiting times without sacrificing quality of care
- It is designed to integrate new clients into the service in a timely fashion, employing evidence-based practice
- Group SLT is the clinical pathway of choice but children are provided with individual SLT if this is necessary to meet their speech and language needs
- It recognises and integrates the central role of parents/caregivers in the SLT process. A key element of MACS is the shared responsibility between the service provider (SLT) and the service user (parents/caregiver).

Methodology

The Waiting List Initiative was introduced in January 2003 and rolled out on a planned phased basis across the Northern Area Health Board (NAHB).

The SLT Teams in each area completed the administration required for the groups. All parents attended training to facilitate carryover of learned skills to the non-clinical environment.

That Waiting List initiative has led to significant reduction in waiting times and access for both assessment and therapy. The waiting time for assessment reduced by up to 75% and the waiting time for therapy reduced by up to 80%. Formative evaluation is currently underway.

Table 2 - Assessment Waiting Times

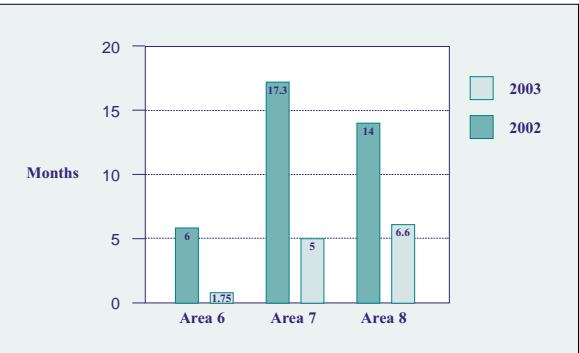
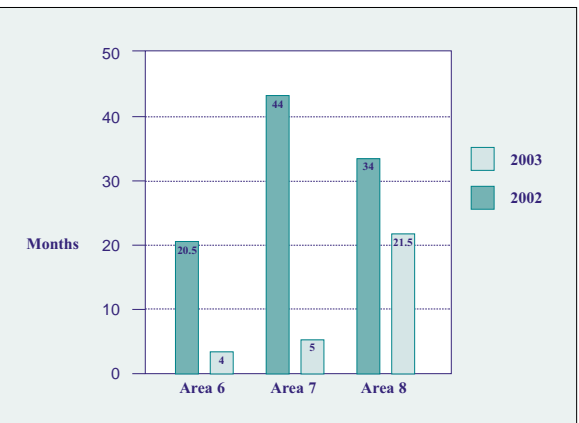


Table 3 - Therapy Waiting Times



Results

- A search for solutions was conducted by the SLT service. The MACS Model was adopted, expanded and tailored to meet the local needs of the community paediatric population in the Northern Area Health Board region.
- Parents/caregivers have become active participants in the SLT process and this significantly improves carryover and outcome. Initial questionnaire feedback from parents has been extremely positive.
- The flexibility in structure and timetabling of sessions allows parents to choose the timing of intervention most appropriate to their individual situations.

Conclusions

- If services work in partnership with clients/caregivers, similar improvements in quality of care and outcome will follow.
- Motivation, flexibility, team-working, negotiation, co-operation and an in-depth knowledge of issues at a local level is essential to drive change.
- Global solutions are available and appropriate.
- Positive changes when implemented do not have to be extremely costly.
- This solution was borne out of a desire by the highly motivated professionals delivering the service to improve that service.
- A formal evaluation of the Waiting List Initiative carried out by Trinity College Dublin has commenced in October 2004.

Presented

At the National Showcase for Public Service Excellence in Dublin Castle on July 8th, 2004 by Ms. Noreen Murphy, Ms. Lisa Ryan and Ms. Mary Morrissey, having been selected as one of the top twenty projects. This event was hosted by The Departments of An Taoiseach and Finance to highlight examples of public service excellence and innovation.

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Research in Progress ~ Health Promotion

Title

Rural Health Project

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Introduction and Rationale

Research has shown a need for a community based approach to address health and well being in rural communities. Farmers are a high-risk group whose health (Physical and Mental) and social needs are not being addressed successfully in Ireland today. Despite ongoing improvements within the health service at large, to date appropriate and successful access to health care services for farmers/farming communities have yet to be identified. As a result the Limerick Health Promotion Team of the Mid-Western Health Board and West Limerick Resources (WLR), a community development organisation, joined together to determine an appropriate and realistic approach to meeting these health and social needs.

Methodology

The project involved meeting farmers in the community at traditional farming meeting points e.g. creameries and marts. Firstly, farmers were invited to avail of a free health check up in terms of assessing Blood Pressure, Weight and Height and an assessment of risk factors for Coronary Heart Disease. They received a personal heart health profile summary to take home. They were then invited to discuss in confidence issues on farming and issues on their own personal lifestyle i.e. behaviours, stress and isolation. At a later date they were invited to take part in a Focus Group to further discuss Farmers Health.

To date we have visited one Creamery, one Mart and two Co-Operative Stores to carry out the first part of the needs assessment. We have also facilitated a number of focus groups.

Workshop Topics include:

- General Health
- Stress and isolation
- Farming issues
- Men's Health
- Access to Health Services
- Identify supports from Health Services/Community Development Agencies/Community Setting

The total number of farmers interviewed was 75.

Results to date

- The most evident fact reported was that farmers did not know whether they had ever had their bloods checked for cholesterol/triglycerides or sugar levels.
- They only visited their GP when very sick.
- There was a high number of farmers with high blood pressure.
- Many farmers were interested in learning more about diet and stress relief.

Conclusion

Many factors above have identified the need for some form of intervention strategy for men's health and in this case farmers health. Methods of supporting farmers to take responsibility for their own health are definitely necessary. Based on the information received we are attempting to support farmers to form a social/discussion group which will support their social and educational needs. The project is ongoing with the aim of identifying easier points of entry to health services.



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- Results
Confirming or refuting the hypothesis, supported by statistics if appropriate
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Stating the major new findings of the study and specifying what these findings add to what is known already
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